COVA Care Basic Plan Summary of Benefits

This chart is an overview of your benefits for covered services under the basic plan. They are listed in detail beginning on page 15. A list of services that are not covered begins on page 33. Optional benefits, which may be purchased for additional cost, are shown beginning on page 82.

What will I pay?

This chart shows what you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage, along with your copayment or coinsurance amounts.

Most services are not subject to a lifetime maximum amount. However, a few *other covered services* do have a $1,500,000 lifetime maximum for each covered person. Should you meet your lifetime maximum amount, *your health plan* will annually reinstate the amount that it paid for *other covered services* during the previous year, not to exceed $2,000. *Other covered services* include ambulance travel, medical equipment, etc. They are defined on page 71. Please also see the **Claims and payments** section on page 42 for more information on the lifetime maximum.

Your coverage also includes a separate $25,000 lifetime maximum for each covered person for the identification of a suitable donor for organ and tissue transplant services. See page 29 for organ and tissue transplant coverage.

	In-network		Detail Page number
			
Calendar year deductible (applies as indicated)	$200	$400	42
Your annual out-of-pocket expense limit	$1,500	$3,000	42

	In-network*			Detail Page number
	Copayment	Coinsurance		
Ambulance Travel No calendar year limit	$0	20%	after deductible	15
Dental services (non-routine)	$0	20%	after deductible	17
Diabetic equipment	$0	20%	after deductible	17
Diabetic education	$0	0%		17
Diagnostic tests and x-rays for specific conditions or diseases at a doctor's office, emergency room, or outpatient hospital department	$0	10%	after deductible	18
Dialysis treatments				
Facility	$0	0%		18
Doctor's Office	$0	0%		18
Doctor visits on an outpatient basis				
Primary Care Physicians	$25	0%		18
Specialty Care Providers	$35	0%		18
Early intervention services	Copayment/coinsurance determined by service received.			18

*** Except in an emergency, you do not have Out-of-network benefits unless you purchase the out-of-network option. See Optional benefits section.**

	In-network*			Detail
	Copayment	Coinsurance		Page number
Emergency room visits				
Facility services	$100 *per visit* (waived if admitted)	0%		19
Professional provider services				
Primary Care Physicians	$25	0%		19
Specialty Care Providers	$35	0%		19
Diagnostic tests, shots, x-rays	$0	10%	after deductible	18
Home care services				
Home health services	$0	0%		19
90 - visit calendar year limit				
Home infusion services	$0	0%		19
Home private duty nurse's services	$0	20%	after deductible	20
Hospice care services	$0	0%		20
Hospital services				
Inpatient treatment				
Facility services	$300 *per stay*	0%		20
Professional provider services				
Primary Care Physicians	$0	0%		20
Specialty Care Providers	$0	0%		20
Outpatient treatment				
Facility services	$100	0%		20
Professional provider services				
Primary Care Physicians	$25	0%		20
Specialty Care Providers	$35	0%		20
Diagnostic tests, shots, x-rays	$0	10%	after deductible	18
Maternity				
Professional provider services				
Prenatal and postnatal follow-up care				
Primary Care Physicians	$25	0%		21
Specialty Care Providers	$35	0%		21
Delivery				
Primary Care Physicians	$0	0%		21
Specialty Care Providers	$0	0%		21
Hospital services for delivery delivery room, anesthesia, nursing care for newborn	$300 *per stay*	0%		21
Diagnostic tests	$0	10%	after deductible	18
Medical equipment, appliances, and supplies	$0	20%	after deductible	22

*** Except in an emergency, you do not have Out-of-network benefits unless you purchase the out-of-network option. See Optional benefits section.**

	In-network*			Detail
	Copayment	Coinsurance		Page number
Mental health and substance abuse treatment				23
Administered by Magellan Behavioral Health				
Inpatient treatment				23
Facility services	$300 *per stay*	0%		23
Professional provider services	$0	0%		23
Partial day program	$300 *per stay*	0%		23
Outpatient treatment				
Facility services	$100	0%		23
Specialty Care Providers	$35	0%		23
Employee assistance program	$0	0%		23
Four visits per incident				
Shots (allergy and therapeutic injections) at a doctor's office, emergency room or outpatient hospital department	$0	10%	after deductible	27
Skilled nursing facility stays				27
180-day per stay limit				
Facility services	$0 *per stay*	0%		27
Professional provider services	$0	0%		27
Spinal manipulations and other manual medical interventions				
$500 calendar year limit				
Primary Care Physicians	$25	0%		27
Specialty Care Providers	$35	0%		27
Surgery				28
Inpatient				
Facility services	$300 *per stay*	0%		28
Professional provider services				
Primary Care Physicians	$0	0%		28
Specialty Care Providers	$0	0%		28
Outpatient				
Facility services	$100 *per visit*	0%		28
Professional provider services				
Primary Care Physicians	$25	0%		28
Specialty Care Providers	$35	0%		28
Diagnostic tests, shots, x-rays	$0	10%	after deductible	18
Therapy - outpatient services ****				
Cardiac rehabilitation therapy				
Hospital services	$0	0%		30
Professional provider services	$0	0%		30

*** Except in an emergency, you do not have Out-of-network benefits unless you purchase the out-of-network option. See Optional benefits section.**

**** See Hospital services for payment amounts for inpatient therapy.

	In-network*			Detail
	Copayment	Coinsurance		Page number
Chemotherapy				
Hospital services	$0	0%		30
Professional provider services	$0	0%		30
Infusion Therapy				
Hospital services	$0	0%		30
Professional provider services	$0	0%		30
Occupational therapy visits				
Hospital services	$35	0%		30
Professional provider services				
Primary Care Physicians	$25	0%		30
Specialty Care Providers	$35	0%		30
Physical therapy visits				
Hospital services	$35	0%		30
Professional provider services				
Primary Care Physicians	$25	0%		30
Specialty Care Providers	$35	0%		30
Radiation therapy				
Hospital services	$0	0%		30
Professional provider services	$0	0%		30
Respiratory therapy				
Hospital services	$0	0%		31
Professional provider services	$0	0%		31
Speech therapy visits				
Hospital services	$35	0%		31
Professional provider services				
Primary Care Physicians	$25	0%		31
Specialty Care Providers	$35	0%		31
Vision correction after surgery or accident	$0	20%	after deductible	31
Wellness services				
Well child				
Office visits at specified intervals through age 6				
Primary Care Physicians	$25	0%		31
Specialty Care Providers	$35	0%		31
Immunizations				
Primary Care Physicians	$0	0%		31
Specialty Care Providers	$0	0%		31
Screening tests	$0	10%	no deductible	31
Routine wellness and preventive care				
Routine wellness (age 7 and older)				
Annual check-up visit				
Primary Care Physicians	$25	0%		32
Specialty Care Providers	$35	0%		32
Immunizations**				
Primary Care Physicians	$0	10%	no deductible	32
Specialty Care Providers	$0	10%	no deductible	32
Lab and x-ray services**	$0	10%	no deductible	32

**Your health plan pays 90% coinsurance up to $200 per calendar year for routine immunizations, lab and x-ray services.

*** Except in an emergency, you do not have Out-of-network benefits unless you purchase the out-of-network option. See Optional benefits section.**

	In-network*			Detail
	Copayment	Coinsurance		Page number
Colorectal cancer screenings	$0	10%	no deductible	32
Preventive care				
Annual gynecological exam				
Primary Care Physicians	$25	0%		32
Specialty Care Providers	$35	0%		32
Annual Pap test	$0	10%	no deductible	32
Annual mammography screening	$0	10%	no deductible	32
Prostate exams (digital rectal exams)				
Primary Care Physicians	$25	0%		32
Specialty Care Providers	$35	0%		32
Prostate specific antigen test	$0	10%	no deductible	32

	Copayment	Detail Page number
Prescription drugs		24
Retail pharmacy		24
covered drugs per 34-day supply		
First tier	$15	24
Second tier	$20	24
Third tier	$35	24
Medco Health Home Delivery Services		26
covered drugs for up to a 90-day supply		
First tier	$30	26
Second tier	$40	26
Third tier	$70	26

Dental services (routine)

Calendar year deductible	$0
The most Anthem will pay per calendar year	$1200

	Copayment	Coinsurance	Detail Page number
Diagnostic and preventive services	$0	0%	15
Primary services (no deductible)	$0	20%	16